# ARIZONA LONG TERM CARE SYSTEM

## APPENDIX A

## PREADMISSION SCREENING MANUAL

## FOR

## ELDERLY AND PHYSICALLY DISABLED (EPD)


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**ADDITIONAL APPENDICES**

# INTRODUCTION

## Legislation

The Arizona State Legislature passed legislation in 1987 expanding the federally funded AHCCCS services to include long term care (LTC). As a result, the Arizona Long Term Care System (ALTCS) was established with an initial implementation date of January 1, 1989 for the elderly/physically disabled population (EPD). To receive federal Medicaid funds for an individual, AHCCCS Administration must demonstrate that an ALTCS customer has a medical need for these services, and is at immediate risk of institutionalization in a nursing facility (NF).

On September 1, 1995, federally funded LTC services were expanded to include the ALTCS Transitional Program. This program allows currently eligible ALTCS customers who have improved and are no longer at risk of institutionalization but still require some LTC services, to receive HCBS services at a lower level of care. For more information on the Transitional Program see ALTCS Eligibility Policy and Procedures Manual, chapter 1000, section 1022.

## LTC

Long Term Care refers to ongoing services required by individuals who are in need of care comparable to that received in a nursing facility (NF). These services represent a wide range of health related services above the level of room and board and offer professional services directed towards the maintenance, improvement, or protection of health or lessening of illness, disability or pain. These professional level services include but are not limited to:

1. 24 hour licensed nurse supervision.

2. All care is under direction of a physician who must make routine visits at intervals of at least 30 to 90 days or more often.

3. Development of a care plan by a multidisciplinary team of professionals (e.g., nursing, social services, registered therapists, registered dietitian) who frequently assess medical progress.

## HCBS

These long term care services may include home and community based services (HCBS) that offer an alternative to institutional care. ALTCS offers the alternatives in order to ensure that the customer in need of institutional level of care may be treated in the least restrictive environment. HCBS is appropriate for customers who would require institutionalization, but who can retain a more independent lifestyle with services provided in the home and community setting where the absence of 24 hour licensed nurse supervision will not endanger their health or safety.

## Preadmission Screening (PAS)

The EPD PAS tool is used to assess the functional, medical, nursing and social needs of the customer. Meeting or exceeding a threshold score on this screening tool establishes initial eligibility for institutional level services (Arizona Revised Statutes §36-2936). A combination of weighted functional and medical factors are evaluated and assigned a numerical value to reach totaled scores. The threshold score, or point at which a customer becomes eligible, is determined by a formula utilizing those scores. The purpose of the functional/medical threshold is to ensure that customer's deemed eligible for ALTCS require a NF level of care.

The eligible customer needs long term care at a level of care comparable to that provided in a nursing facility, but **below** an acute care setting (hospitalization or intense rehabilitation) and **above** a supervisory/personal care setting, intermittent outpatient medical intervention, or benevolent oversight. A customer, already enrolled with an AHCCCS acute health plan, and who needs less than 90 days of convalescent care may be ineligible for ALTCS. A customer who does not have a nonpsychiatric medical condition or developmental disability also may not be eligible.

## Customer Profiles

In the aggregate, the eligible ALTCS customer will have a functional and/or medical condition that is so impaired as to interfere substantially with the capacity to remain in the community, and results in long term limitation of capacity for self care. A customer who meets ALTCS criteria for Title XIX eligibility will present with a combination of the following needs or impairments:

1. requires nursing care by or under the supervision of a nurse on a daily basis;

2. requires regular medical monitoring;

3. impaired cognitive functioning;

4. impaired self care with activities of daily living;

5. impaired continence;

6. psychosocial deficits.

## Eligibility Review

When a customer's medical eligibility for Title XIX services is not adequately defined by the scoring criteria, but in the Medical Eligibility Specialist's professional opinion the customer's overall condition is correlated with the needs or impairments as outlined above, the case may be referred for eligibility review to a consultant physician or an administrative review.

It is important to remember that there is no singular definition for the level of care for ALTCS medical eligibility. An eligible customer might have a combination of factors that impact their functional ability and medical need for services.

## Population Assessed

The population assessed with the EPD PAS Tool includes the elderly, the physically disabled (age 6 and over) and also the developmentally disabled residing in a nursing facility. A separate tool is used to assess children under age 6 and persons with developmental disabilities (DD). The PAS tool may also be used to determine whether private customers or those not funded by Title XIX are at risk for NF care. These customers will be assessed upon request.

## Assessment Team

The tool is completed by a registered nurse or a social worker who will use professional judgment based on education, experience and ongoing inservice training to describe the customer's functional ability and current medical status. If the customer is ventilator dependent, the assessment will be conducted by a registered nurse. A thorough assessment will include a personal interview with the customer and caregiver, and a review of pertinent medical records or information as applicable.

## Client Issue Referral (CIR)

When situations are identified that pose immediate and/or serious threat to the customer's well being (e.g., suicidal threats, environmental hazard, or suspected physical abuse or neglect), appropriate health providers and/or authorities (Adult/Child Protective Services, police, paramedics, guardians) as well as the Medical Eligibility Specialist supervisor, should be notified as soon as possible. Documentation of the referral (person notified, date and description of the incident) should be entered into the PAS case notes and/or an AHCCCS Client Issue Referral Form completed. For more information on CIR, see the ALTCS Eligibility Policy and Procedure manual, chapter 1000, section 1019.

## PASRR

The Medical Eligibility Specialist should be aware that all nursing facility (NF) residents and applicants to Medicaid certified nursing facilities must be assessed through the Preadmission Screening and Resident Review (PASRR) process. The PASRR is a two-level screening process for mental illness/mental retardation and mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) as a portion of NF reform measures. For further information regarding PASRR, see the ALTCS Eligibility Policy and Procedure Manual, chapter 1000, section 1020.

## PAS Tool Sections

The ALTCS Preadmission Screening tool consists of several sections. These sections are:

- Intake information
- Functional assessment
- Emotional and cognitive functioning
- Medical assessment
- Eligibility review

This manual provides instructions for completing the PAS tool and guidelines for making assessment decisions. For more information regarding PAS, see ALTCS Eligibility Policy and Procedure Manual, Chapter 1000.

## ACE

The information obtained will be entered into the computerized AHCCCS Customer Eligibility (ACE) System, which is the management system supporting the PAS.

# I. INTAKE INFORMATION

## A. REFERRAL INFORMATION

The PAS Intake Notice is generated from the at the AHCCCS Customer Eligibility (ACE) System at the time of the PAS referral from the Financial Eligibility Specialist.

The PAS assessor should verify that the information on the PAS Intake Notice is complete and accurate, and should notify the Financial Eligibility worker of changes or errors.

The PAS Intake Notice will be comprised of the following fields:

**Customer**

The applicant's last name, first name and middle initial.

**Customer ID Number**

This is the identifying number associated with the customer.

**ALTCS Office**

This is the Medical Eligibility office assigned to complete the PAS. It will usually be the office where the application was taken, but Financial Eligibility may refer the PAS to a different site if they know the client is placed in an area where another PAS office has authority.

**PAS Type (Initial, Posthermores, Private Request)**

**AHCCCS ID**

This is the unique identifier for the AHCCCS system. An customer has only one AHCCCS ID. New customers who have not been AHCCCS members will not have an AHCCCS ID at this point.

**Health Plan Name**

**Health Plan Phone**

**Application Date**

**Referral Date**

**PAS Due Date**

This is the date the PAS is due. This date is six days before the end of the application period for the case. The application period is 45 days from the application date.

**DD (Developmental Disability) Status**:

This is the DD status at the time of referral.

1 = Potential DD
2 = DD
3 = DD in a Nursing Facility
4 = Not DD

If there is any question about DD status, this should be investigated and reconciled immediately. Status may be investigated by conferring with Financial Eligibility and the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). For more information on DD status see section D 11 of this manual and Chapter 1000 of the ALTCS Eligibility Policy and Procedure Manual.

**Age**

This is the customer's age in years. For children under 3 years old, the age will be displayed in months. Children under 6 years of age will be assessed using the DD tools. It is important to note the child's age. If the child is close to changing age groups, the PAS may need to be delayed to ensure assessment with the proper tool. These cases should be discussed with a supervisor.

**AHCCCS Member?**

This identifies if an ALTCS customer is already eligible for AHCCCS acute services. Usually, these customers are enrolled with an AHCCCS health plan. The application process, including PAS, is expedited for health plan members. If an initial ALTCS customer is a health plan member and is not expected to need more than 90 days of long term care, they may not be eligible for ALTCS. The acute health plan is responsible for up to 90 days of convalescent care. Cases that might belong in this category should be referred to the physician for eligibility review. (Please refer to section F on eligibility review). Any customer that seems to need less than 90 days of convalescent care should have their AHCCCS health plan enrollment verified by reviewing computer screen RP285 or RP160. A name search can be conducted by using the RP290 screen.

**DOB**

Date of Birth

**SSN**

Social Security Number

**Gender**

Male or Female

**Language**

The applicant's primary language.

**Marital Status**

Marital status.

**Residence Address (City, State, Zip code)**

The customer's address at the time of referral. If the applicant is in a facility, the facility address will be the residence address.

**Mailing Address (City, State, Zip Code)**

The customer's mailing address.

**Phone**

The facility phone number (if applicable).

**Residence County**

The county in which the applicant currently resides.

**Residence Phone Number**

The applicant's residence phone number.

**Authorized Representative**

A person authorized by the customer, legal representative, or .

**Residence Phone Number**

This is the contact person's residence phone number (if applicable).

**Relationship**

This is the relationship of the customers representative to the applicant.

**Business Phone Number**

This is the business phone number of the customer's representative (if applicable).

**Location Type**

This is a code that describes the living arrangement of the applicant. If a PAS Intake Notice is not available, the assessor should write in the location and phone number at the time of the assessment as indicated on the form.

**Facility**

If the applicant is in a nursing facility or hospital, the provider number and name will appear here.

**Admission Date**

The date of admission to the facility (if applicable).

**Date of Death**

The date of death will be on the PAS Intake Notice if the EI was aware at the time of the referral that the applicant was deceased.

## If Different From Above

The Intake Notice has space at the bottom to indicate a change or a correction to residence address, mailing address, residence county and phone number, facility name and phone number, and admission date. Date of death may be entered, if applicable. Any other changes or corrections to the information on the Intake Notice should be written in under "Other Changes", and a copy sent to the FES.

## Private Request PAS

This will not be on the PAS Intake Notice printed by the system, but should be indicated if a page one (1) form is used. A Private Request PAS could be done on an individual who is **not an applicant for ALTCS** but who requests, for whatever reason, to have PAS status determined.

## B. ASSESSMENT

The PAS form includes the name of the Medical Eligibility Specialist (MES) as well as demographic information about the customer that must be obtained by the PAS specialist.

### Assessment

The date of the PAS interview displays in this field.

### Customer Age

### Assessor(s)( (MES)

The name of the registered nurse and/or social worker completing the PAS should be entered here.

DD Status

If the status on the PAS Intake Notice is questionable based upon your personal observation or other information obtained, indicate the status that appears to be most accurate **and inform your supervisor**. This field is to be completed for all applicants. The codes are defined as follows:

1 = Potential. Customer appears to have mental retardation, cerebral palsy, seizure disorder or autism, but has not been determined to be developmentally disabled by DES/DDD. S/he is referred to DES/DDD for evaluation and is assessed using the EPD assessment tool. If DES/DDD has not determined DD status within 30 days, an EPD PAS should be completed and entered in CATS. The customer may find it expedient to complete a DD PAS in addition to the EPD PAS pending DES/DDD eligibility status determination.

2 = DD. Customer has been identified by DES/DDD as developmentally disabled and is assessed using the DD assessment tool.

3 = DD in NF. Customer has been identified by DES/DDD as DD and resides in an ICF or SNF facility and is assessed using the EPD assessment tool.

4 = Non-DD. Customer is not diagnosed as DD or has a DD diagnosis but has been determined ineligible for DD services. Customer is assessed using the EPD assessment tool.

For more information on DD status see Appendix B, and the Eligibility Policy and Procedure Manual, Chapter 1008.

## C. ASSESSMENT INFORMATION

**DD Status**

**Tool Used**

**Assessor**

**Location**

**Telephone number**

**Usual Living Arrangement**

**Enter the applicable setting**. Community refers to an customer who lives in a private home, mobile home or apartment. Nursing facility may be a certified or uncertified facility. Other supervised setting refers to board and care homes, adult foster homes, adult care homes, supervisory care homes, group homes, apartments for assisted living, etc. "Usual" could refer to the customer's living arrangement for approximately the last six months, or if the customer has planned no discharge or relocation from the present living arrangement.

**Usual Living Situation**

**Enter the usual living situation that applies. (select only one).** "Usual" could refer to the customer's current living situation for approximately the last six months or if the customer has planned no discharge or relocation from current living situation. (If an customer resides in a nursing facility or assisted living facility in which a spouse or other family member also resides, #5 with non-relatives should be indicated rather than living with spouse or other relative).

## D. EPD INFORMATION

### Physical Measurements

1. Height - Record approximate height if actual is unknown.
   Respond in feet or inches rather than using the metric system.

2. Weight - Record approximate weight if actual is unknown.
   Respond in pounds rather than using the metric system. Record ideal weight range if available (may be left blank).

### Additional Information

1. Is the customer currently hospitalized or in an intensive rehabilitation facility?
   Answer yes or no as applicable.

2. If in an acute facility, is discharge imminent?
   If discharge is not anticipated within 7 days, the customer is in need of a higher level of care than received in a Nursing Facility and is not eligible for ALTCS. Record the projected discharge date whether discharge is imminent or not.

3. Ventilator dependent?
   This is defined as being on a ventilator **at least 6 hours a day for 30 consecutive days**. The customer who is dependent upon a ventilator will have the PAS conducted by both a social worker and a registered nurse. The assessor must also complete the ventilator dependent work sheet if applicable. It may be necessary for the assessor to obtain information from multiple facilities to determine when the customer started on the ventilator and if they meet the criteria.

4. Number of emergency room visits in the last six months?
   Include approximate dates and reasons for these visits in the summary evaluation.

5. Number of hospitalizations in the past six months?
   Include approximate dates and reasons for hospitalizations in the summary evaluation.

6. Number of falls in the last 90 days?
   Count all falls. If there were any injuries, document in the summary the approximate date and types of injuries which occurred.

## E. SOURCE OF INFORMATION

Indicate whether the information for the interview was obtained by: 1) self-report by the customer (self-report is actively providing information, not just being observed or providing minimal information); 2) review of medical records; or 3) informant/caregiver. If an informant was used, enter in his/her name and title/relationship. **Indicate all that apply**. In most cases, all three will be applicable. **In all cases the customer must be observed** and preferably the interview would occur in the usual living arrangement.

**It is important that the interview be conducted with caregiver(s) or others familiar with the customer.** It is required that family or legal guardian be contacted to be present at the PAS interview if they choose. If the family member or legal guardian is not available to attend the PAS, the customer should contact them to go over the information obtained at the interview.

## F. PERSONAL CONTACTS

This section is designed to elicit information about one personal contact and the customer's physician. The personal contact may or may not be the same representative who has been identified by the FES Financial Eligibility. Fill in the contact's name, relationship to applicant, address, and telephone numbers. Check whether or not the contact assisted with the interview. **Do the same as above for the customer's primary physician.** If medical documentation was received from the physician's office or if a diagnosis was confirmed by the office staff, **this could be considered assisting with the interview process.**

An addendum sheet is available in the event that the assessor needs to obtain and record information about additional contacts.

# II. FUNCTIONAL ASSESSMENT

This portion of the PAS tool is designed to elicit information about the customer's functional abilities in regards to Activities of Daily Living, Continency and Communication/Sensory Patterns. This may be achieved by directly asking questions of the customer, the caregiver and/or by observing the behavior of the customer during the interview process and by reviewing available records. It is important to include the caregiver or family in the interview if at all possible.

**Assessments should be conducted after discharge from acute care facilities, if feasible.**

## A. ACTIVITIES OF DAILY LIVING (ADLs) (30 days)

To evaluate the best environment for a medically or physically disabled person, it is important to first assess the level at which the customer is performing the activities of daily living. The ability to care for self, or independence, is measured by the degree of self reliance in completing these activities of daily living.

The ADLs include: mobility, transferring, bathing, dressing, grooming, eating and toileting. The A/R will be rated on his/her ability to perform these tasks within the **residential environment** or other routine setting. This section is designed to obtain information about the customer's ADLs in the past thirty (30) days. The assessor may provide comments in the space provided. The comments should reflect the reasoning applied for the scores recorded. If it is clearly evident that an customer is in need of more assistance than is received, the assessor may take that into consideration in scoring. This should be done conservatively as it may be difficult to determine the exact amount of assistance needed (for example, only supervision, not physical assistance, may be needed to attain a generally acceptable level of hygiene). **A thorough explanation of this need must be documented in the comments and/or summary.**

Each ADL category contains a set of statements that can be used to describe how well an customer is able to complete the ADL. ADL functions should be rated by selecting the answer most appropriate to the customer's task performance in the current living arrangement. If a major portion of the day is routinely spent in another setting, typical ADL performance in that setting may also be taken into consideration. Since the ADL can be comprised of multiple sub-tasks, all components of the ADL relevant to the customer should be considered in scoring. Some customers will not perform the ADL exactly as described in the statement, **and a comment should be added to explain why the statement selected was assessed to be the best response**. Do not select more than one response.

If the customer's ADL performance was not consistent throughout the 30 day period, please **score the most typical** ADL performance. Then in the comments section, describe any deviations from typical performance. Be sure to include in your comments: (1) how often deviations occurred; (2) under what circumstances deviations occurred; and (3) the ADL functioning level of the customer during the period of deviation from typical ADL performance.

Short-term or transient episodes of deviation from typical ADL performance such as having the flu or otherwise being temporarily “under the weather’, would NOT be scored as typical performance. On the other hand, an customer may regularly have “good days’ and “bad days” when ADL performance fluctuates within the month. In these situations the assessor must gather enough information to accurately determine the best score.

A description of each ADL included in the PAS instrument is provided below. The following definitions apply to terms used in the ADL assessment:

- "Some" - less than half of the task.
- "Moderate" - approximately one half to less than three quarters of the task.
- "Extensive" - approximately three quarters of the task or more.
- "Participation" - active participation, not just being passive or cooperative.
- "Supervision" - observing the customer and being readily available to provide assistance.
- "Physically lift" - actively bearing some part of the customer's weight during movement activity (exclude bracing and guiding activity).

## · Mobility

The extent of the customer's **purposeful movement within the residential environment**. The use of assistive devices such as walkers, canes, handrails or wheelchairs should be considered in the assessment, along with adjustment of restraint devices, but the customer should be scored based on the amount of assistance required from another person (this may include set-up of assistive devices).

**NOTE:** ▲ Often an individual with cognitive impairment may require assistance for purposeful movement even though they are ambulatory or self propel a wheelchair.

▲ Ambulating for therapy purposes only is not <u>necessarily</u> purposeful mobility. This <u>may</u> be scored for therapy or rehabilitative nursing but may not be of significant duration to affect purposeful mobility, i.e., 15 minutes 3 times a week.

### Scoring

0) Is mobile without assistance from another person (may use mechanical aids independently).
1) Needs some supervision, reminding or set-up, including adjustment of assistive devices and restraint adjustment.
2) Needs some hands-on physical assistance other than or in addition to initial adjustment of assistive devices or needs moderate to extensive supervision.
3) Needs moderate hands-on physical assistance other than or in addition to initial adjustment of assistive devices.
4) Needs extensive hands-on physical assistance other than or in addition to initial adjustment of assistive devices, but can participate physically.
5) Totally dependent on others for mobility.

## · Transferring

The customer's ability to move horizontally and/or vertically between two surfaces (e.g. the bed, chair, wheelchair, etc.), within the **residential environment**, excluding transfer for toileting or bathing. The assessor should also consider whether the customer requires adjustment of a restraint device in order to transfer.

**Note:** ▲ Assistance to a sitting position in order to facilitate transfer from bed would be considered in scoring transfer.

### Scoring

0) Can transfer without assistance from another person (may use mechanical aids independently).
1) Needs some supervision, reminding or adjustment of restraint device.
2) Needs hands-on physical guidance, but does not have to be physically lifted, or needs supervision with more than half of transferring activities.
3) Needs to be physically lifted, or moved, but can participate physically (e.g., customer pivots, holds on or braces self to assist caregiver).
4) Must be totally transferred by one or more person(s) or is bedfast.

## · Bathing

This is the process of washing, rinsing and drying all parts of the body. Bathing includes the customer's ability to wash the face and hair and to transfer to the tub or shower. It may be a tub bath, shower, bedbath or sponge bath. It also includes the ability to obtain the bath water and/or equipment, whether this is in bed, tub, shower, or at a sink. Mechanical aids such as tub/shower chair, grab rails, pedal/knee controlled faucets, mechanical lifts, long-handled brush, etc., should be considered in the assessment but **scoring** should be based on the assistance required from another person.

**NOTE:** ▲ If the customer has a bed bath, transfer does not apply;

▲ If hair is routinely washed by a beautician due to personal preference, shampooing may be excluded from scoring.

**Scoring**

0) Can bathe or shower without assistance from another person (may use mechanical aids independently).
1) Needs some supervision, reminding or set-up, but does not need physical assistance into the tub or shower.
2) Needs some hands-on physical assistance, but does not need to be physically lifted into the tub or shower, or needs supervision with more than half of bathing activities.
3) Needs moderate hands-on physical assistance, but does not need to be physically lifted into tub or shower.
4) Needs extensive hands-on physical assistance, but can participate physically, and/or includes physically lifting into the tub or shower.
5) Must be totally bathed by another person.

## · Dressing

The physical process of choosing and putting on clean clothing and footwear (**including** weather appropriate but **excluding** aesthetic concerns such as matching colors), securing fasteners, and removing articles of apparel. **This includes artificial limbs, braces and other appliances which are needed daily.** The use of mechanical aids (such as zipper pulls, long-handled shoe horn, dressing stick, stocking aid, velcro fasteners, etc.) and adaptive clothing (elastic waist pants, slip-on shoes or non-button shirts) does not disqualify the customer from being considered independent.

**NOTE:** ▲ If the customer requires greater assistance because s/he does not have mechanical aids, **select the current level of assistance required** and use the comments section to elaborate.

▲ The use of diapers would not be scored in dressing but would be considered in toileting.

**Scoring**

0) Can dress without assistance of another person (may use mechanical aids independently).
1) Needs some supervision, reminding or set-up (e.g., laying out clothes, giving advice, or being available).
2) Needs some hands-on physical assistance, or supervision with more than half of the dressing activities.
3) Needs moderate hands-on physical assistance.
4) Needs extensive hands-on physical assistance, but can participate physically.
5) Must be totally dressed by another person.

## · Grooming

The process of tending to one's appearance. This may include combing or brushing hair, washing face and hands, shaving, routine nail care, oral hygiene (including denture care), and menstrual care.

**NOTE:** ▲ This **excludes** aesthetics such as styling hair, skin care and applying make-up.

▲ If manicure/pedicure/shaving is routinely done by barber or beautician, due to personal preference rather than necessity, exclude these from scoring.

### Scoring

0) Can groom without assistance from another person (may use mechanical aids independently).
1) Needs some supervision, reminding or set up (e.g., giving advice, or being available). Hands on nail care only would be scored here since the task is infrequent relative to other grooming activities.
2) Needs some physical assistance, or supervision with more than half of grooming activities.
3) Needs moderate hands-on physical assistance.
4) Needs extensive hands-on physical assistance, but can participate physically.
5) Must be totally groomed by another person.

## · Eating

The process of putting food and fluids by any means into the digestive system. The use of tube feeding or IV feeding should also be considered in the assessment.

**NOTE:** ▲ Tube feeding formula is considered alteration of food.

▲ Alteration of food is considered in scoring but preparing food (i.e., cooking) is not scored.

▲ Serving food or delivering a meal is not considered in set-up. Set-up is: opening milk cartons, cutting food or otherwise setting up food to facilitate eating, i.e., clockwise arrangement for visually impaired.

**Scoring**

0) Can eat without assistance from another person (may use mechanical aids independently).
1) Needs some supervision, reminding or set-up including alteration of food (e.g., cutting, pureeing).
2) Needs some hands-on physical assistance or needs supervision with more than half of eating activities.
3) Needs moderate hands-on physical assistance.
4) Needs extensive hands-on physical assistance, but can participate physically.
5) Must be totally orally fed and/or diet is augmented by tube feedings or TPN by another person.
6) Needs tube feeding or IV feeding (TPN) administered by another person as the primary means of nourishment (may accept some nourishment orally).

## · Toileting

The process involved in managing the elimination of urine and feces in the appropriate place(s). Toileting includes transferring to and from the commode or bedpan, cleaning self, changing diapers or incontinence pads, emptying catheter or ostomy bag, removing waste and adjusting clothes.

**NOTE:** ▲ Emptying bedpans, commode chairs and urinals are included as set-up activities.

▲ Changing an ostomy bag and/or wafer would be rated under ostomy care.

**Scoring**

0) Can toilet without assistance from another person (may use mechanical aids independently).
1) Needs some supervision, reminding or set-up (e.g., emptying bedpan, urinal, commode chairs or flushing); does not need physical assistance onto the toilet.
2) Needs some hands-on physical assistance, but does not need to be physically lifted onto the toilet, or needs supervision with more than half of toileting activities.
3) Needs moderate hands-on physical assistance, but does not need to be physically lifted onto the toilet.
4) Needs extensive hands-on physical assistance with toileting in bowel and/or bladder activities, but can participate physically, and/or must be physically lifted onto the toilet.
5) Totally dependent for toileting with both bowel and bladder.

- **Change In ADL Function (90 days)**

This question is used to identify whether significant overall changes occurred in the customer's status, skills or abilities compared to **90** days ago.

**Scoring**

0) No change - No change in the customer's function.
1) Improved - customer's ADL function has improved.
2) Deteriorated - customer's function has deteriorated.

The assessor **must provide an explanation of the reason** for any change in ADL performance or if the overall status hasn't changed but there have been fluctuations within the 90 days.

**NOTE:** ▲ On reasssessment remember to assess the last 90 days, not since the last PAS.

## B. CONTINENCE (30 days)

The assessor will identify the item that best describes the customer's level of control of bowel and bladder evacuation in the last **30 days. These questions do not refer to toileting ability**. An individual who is totally incontinent may still be independent in toileting.

**NOTE:** ▲ A history of transient incontinence caused by an acute or temporary condition or illness (e.g., acute urinary tract infection or episode of diarrhea) should not be considered for rating.

▲ Incontinence during seizure activity should not be considered unless frequent seizure activity affects overall continency.

▲ Those who willfully toilet in inappropriate places will not necessarily be assessed as being incontinent, but these behaviors may be assessed in other parts of this tool (toileting/disruptive behaviors).

▲ Incontinence involving minimal amounts (not necessitating an immediate change of clothing) should usually be rated as continent.

The following definitions apply to terms used in this section:

- "Continence" ability to voluntarily control the discharge of body waste from bladder or bowel.
- "Incontinence" involuntary loss of bowel or bladder contents.
- "Stress Incontinence" inability to prevent escape of small amounts of bowel/bladder contents during certain activities such as coughing, lifting or laughing.

## · Bowel Continence

The ability to voluntarily control the discharge of body waste from the bowel.

**NOTE:** ▲ Those who have no voluntary control and rely upon dilation or ostomies for evacuation should be rated as totally incontinent of bowel.

**Scoring**

0) Continent. Complete voluntary control.
1) Incontinent episodes less than weekly.
2) Incontinent episodes once a week.
3) Incontinent episodes two or more times a week and/or no voluntary control.

## · Bladder Continence

The ability to voluntarily control the discharge of body waste from the bladder.

**NOTE:** ▲ Those who have no voluntary control and rely upon indwelling catheters, intermittent catheterization, ostomies or condom catheters for evacuation should be rated as totally incontinent of bladder.

▲ Those who receive dialysis **and** do not urinate will be rated as continent.

**Scoring**

0) Continent - Complete voluntary control or minimal stress incontinence/dribbling.
1) Usually Continent - Incontinent episodes once a week or less.
2) Occasionally Incontinent - Incontinent episodes two times per week, but not daily.
3) Frequently Incontinent - Incontinent daily, but some control present (e.g. day time).
4) Totally Incontinent - Incontinent episodes multiple times daily and/or no voluntary control.

## · Change In Bladder Continence (90 days)

This section is used to identify changes that may have occurred in the customer's present bladder functioning **as compared to 90 days ago.**

**Scoring**

0) No change - No change in bladder control.
1) Improved - Bladder control has improved.
2) Deteriorated - Bladder control has deteriorated.

The assessor **must** provide an explanation if there was a change in bladder continence, or if overall the status hasn't changed, but there have been fluctuations within the 90 days.

**NOTE:** ▲ On reassessment remember to assess the last 90 days, not since the last PAS.

## C. COMMUNICATION/SENSORY PATTERNS (30 days)

These questions are used to evaluate hearing, vision and communication abilities in the past **30 days.** The assessor should circle the item that best describes the usual level of functioning in each category. Assessment may be made by reviewing available information from the caregiver, customer, medical records and observation.

**NOTE:** ▲ **If the assessor is unable to assess the ability, this will be scored in the "0" or unimpaired category.**

▲ **Customers who are unable to respond due to coma will be scored as having maximum impairment**.

### · Hearing

The ability to perceive sounds. If an assistive device is used, hearing should be rated while using the device. Hearing refers to the ability to receive sounds, and does not refer to the ability to mentally comprehend the meaning of the sound.

**Scoring**

0) Hears adequately - Hears all normal conversational speech, including when using the telephone, watching television, and participating in group activities or unable to assess.
1) Minimal difficulty - Hears speech at conversational levels but has difficulty hearing when not in quiet surroundings or when not in one-on-one situations.
2) Hears in special situations only - Although hearing-deficient, compensates when speaker adjusts tonal quality and speaks distinctly; or can hear only when speaker's face is clearly visible, or may only hear loud conversation.
3) Highly impaired/absence of useful hearing - Hears only some sounds; frequently fails to respond even when speaker adjusts tonal quality, speaks distinctly, or faces customer. May only hear very loud voice or is totally deaf.

## · Expressive Communication

The ability to express information and make self understood by using any means (e.g., verbal, written, signs, etc). This area may be affected by mental status or physiological conditions.

### Scoring

0) Understood - Customer expresses ideas clearly or unable to assess.
1) Usually Understood - Customer has difficulty finding the right words or finishing thoughts, resulting in delayed responses and/or requires some prompting to make self understood due to unclear speech.
2) Sometimes Understood - Customer has limited ability, but is able to express concrete requests regarding at least basic needs such as food, drink, sleep and toilet.
3) Rarely or Never Understood - At best, understanding is limited to caregiver interpretation of highly individual body language or specific sounds (indicating presence of pain or need to toilet).

## · Vision

The ability to visually perceive objects. A medical condition or disease affecting the eye that does not affect the ability to see should not be considered in determining adequacy of sight. In this section, the assessor will evaluate the A/R's ability to see close objects and objects at a distance in adequate lighting, using any usual visual appliances (e.g., glasses, magnifying glass).

**NOTE:** ▲ A diagnosis of legal blindness does not reflect a specific level of impairment for PAS scoring. For example, an individual may be able to read large print and be legally blind.

### Scoring

0) Sees adequately - There is no impairment or impairment is compensated by corrective lenses; can see newsprint, TV, medication labels or unable to assess.
1) Impaired - Difficulty with focus at close (reading) range but can see large print and obstacles but not details. May have monocular vision but has been able to compensate.
2) Highly impaired - Very poor focus at close range. Unable to see large print and/or field of vision is limited (tunnel vision or central vision loss).
3) Severely impaired - May see only light, shapes, colors or has no vision.

## III. EMOTIONAL AND COGNITIVE FUNCTIONING

These questions are intended to measure the frequency of specific behaviors and the extent to which these behaviors impose caregiving requirements on others or interfere with self-care. Caregiving can include either supervision or intervention.

### A. ORIENTATION (90 days)

Orientation is defined as the individual's awareness of one's self in relation to person, place and time. The assessor should consider orientation for the last **90** days, placing the most emphasis on recent mental status as well as the ability to reorient self.

**NOTE:**

- ▲ A customer who is aware of forgetfulness and initiates self reorientation (asking questions, looking at clock/calendar) will usually be considered to be oriented.
- ▲ Temporary disorientation due to an acute condition may not be considered if the customer has recovered (i.e., electrolyte imbalance, intoxication).
- ▲ Allowances should be made for those persons in cultures/environments where time/place is traditionally measured in general rather than specific terms.
- ▲ Forgetfulness and confusion does not necessarily indicate disorientation. The ability to re-orient the frequency and intensity of the forgetfulness and confusion need to be assessed to determine level of orientation.
- ▲ Unable to assess is not a scoring option. Every attempt to gather enough information to assess orientation should be done by asking the customer, caregivers and others familiar with the customer, about the customer's orientation to person, place and time.
- ▲ A customer in a coma should be scored as totally disoriented to all 3 factors.
- ▲ A child customer should be assessed in regards to age appropriate knowledge of person place and time. For example, do they know familiar settings, do they know morning and night?
- ▲ It is important to remember that individuals with emotional or cognitive impairment may not be good historians. Corroboration of information is important in these cases.

- ▲ An customer who is aphasic (has difficulty speaking) may need to be assessed using alternate means such as asking multiple choice questions, asking the customer to write or use some other way to communicate. The caregiver should be helpful in determining whether or not the customer is disoriented.

- ▲ This section is not assessing things never known or never learned.

- ▲ It is best to record the customer's actual responses in quotations and comment as to corroborating information.

The assessor should determine the level of orientation to the following dimensions:

+ **Person** - Awareness of current first and last name. Does not include other persons.

  **Scoring**

  0) No problems with orientation.
  1) Disoriented occasionally (approximately 3 times or less per month).
  2) Disoriented some of the time (more than 3 times per month but less than half of the time).
  3) Disoriented at least half of the time.

+ **Place** - Awareness of current location (residence, city, state). Residence may be considered accurate if stated in somewhat generalized terms (e.g., "my son's house", a nursing home, etc.).

  **NOTE: Exact address does not need to be known.**

  **Scoring**

  0) No problems with orientation.
  1) Disoriented occasionally (approximately 3 times or less per month).
  2) Disoriented some of the time (more than 3 times per month but less than half of the time).
  3) Disoriented at least half of the time.

+ **Time** -Awareness of current time frame (date, month, year and time of day). Consideration should be given to those persons in cultures/environments where time passing is traditionally measured in general rather than specific terms (e.g., "winter", "morning", "middle of the week".)

**NOTE:** ▲ An incorrect response of a day or two may not indicate disorientation. The assessor should repeat the response and ask further questions to determine if the customer is able to reorient (e.g., pointing to a calendar, looking at a newspaper).

**Scoring**

0) No problems with orientation.
1) Disoriented occasionally (approximately 3 times or less per month).
2) Disoriented some of the time (more than 3 times per month but less than half of the time).
3) Disoriented at least half of the time.

**Disorientation to any segment of the item being measured will be scored as disoriented with comments to explain.**

## B. BEHAVIORS (90 days)

The purpose of this section is to identify the presence of certain inappropriate behaviors that may reflect the level of an individual's emotional and cognitive functioning. Behaviors should be assessed **based on the last 90 days,** except as indicated in self-injuries behavior and aggression. If a particular behavior has been exhibited in the past (more than 90 days ago), but is no longer a problem, then the assessor may indicate a history of the problem by selecting the appropriate response. Responses are based on both the frequency and the intensity of the behavior, that is the amount or degree of intervention required to control the problem behavior.

**NOTE:** ▲ It may be difficult for the customer to discuss behaviors. Assessors need to be sensitive to this and involve caregivers/family for collateral information.

▲ **It is important to include a description of behaviors and intervention in the comments or summary.**

The following definitions should be applied when answering questions related to behaviors:

| | |
|---|---|
| "Occasionally" | less than weekly. |
| "Frequently" | weekly to every other day. |
| "Constantly" | at least once a day. |
| "Intervention" | therapeutic treatment, including the use of medication and physical restraints to control the behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior. |
| "Medical Attention" | examination by a physician or Primary Care Provider and treatment, if necessary. |

+ **Wandering**

Defined as moving about with no **rational** purpose and with a tendency to go beyond physical parameters of the environment in a manner that may jeopardize safety.

**NOTE:** ▲ Getting lost in an unfamiliar place or voluntarily leaving against medical advice would not be considered wandering. Wandering implies an **impaired ability to reorient** one's self to location.

▲ Typically an individual who wanders will be disoriented to some degree.

**Scoring**

0) Wandering has not been observed. May have a history of wandering behavior that is not a current problem.
1) Occurrences may not pose a safety problem but do require additional supervision or occasional intervention.
2) Occurs predictably (in response to particular situations). Occurrences pose a threat to the safety of self or others requiring frequent supervision and intervention.
3) Occurs constantly posing a threat to the safety of self or others. Requires constant intervention or a secured environment.

+ **Self Injurious Behavior**

Defined as **repeated** self-induced, abusive behavior that is directed toward infliction of **immediate** physical harm to the body (e.g., slapping, cutting, biting, pica [ingestion of inedibles], scratching, compulsive water consumption, headbanging).

**NOTE:** ▲ Exclude suicide attempts, accidents (e.g., falling), or risky lifestyle choices (e.g., smoking, drug/alcohol abuse, and non-compliance with medical advice).

▲ Self-injurious behavior may be deliberate or may be irrational.

**Scoring**

0) No problems in this area. May have a history of injurious behavior that is not a current problem.
1) Occasional incidents which require added supervision or occasional intervention.
2) Frequent incidents; requires constant supervision or frequent intervention.
3) Had episode(s) causing serious injury requiring medical attention **in the past year** and requires supervision to prevent reoccurrence, or requires 24-hour awake supervision or constant intervention.

+ **Aggression**

Defined as **physically** attacking another; includes throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, and physically threatening behavior. Includes destroying property as part of aggressive behavior, but does not include self-injurious behavior.

**Scoring**

0) No problems in this area. May have a history of aggression that is not a current problem.
1) Occasional aggression which requires added supervision and/or occasional intervention.
2) Frequent aggression that requires constant supervision or frequent intervention.
3) Had episode(s) causing serious injury requiring medical attention **in the past year** and requires supervision to prevent reoccurrences, or requires 24 hour awake supervision or constant intervention.

\+ **Suicidal Behavior**

Defined as an act or intent to voluntarily take one's own life (thoughts, threats and/or attempts). An individual **must be cognitively intact** (generally oriented and aware of consequences of behavior to self) to be considered suicidal.

Suicidal behavior **may** include:

- Attempts
- Verbalization/acknowledgment of suicidal urges/threats.
- Preparatory behavior that **may** indicate suicidal intent, (e.g. putting affairs in order, giving away prized belongings, or hoarding lethal medications). These alone DO NOT indicate suicidal intent.
- Having a detailed suicide plan.

Suicidal behavior is **not**:

- Wishing for death.
- Implementing advanced directives to avoid prolonging death.
- Being depressed.
- Taking risks.

Intervention is an active measure undertaken to alleviate/mitigate suicidal behaviors and may include:

Medication - (antidepressants, antipsychotic, tranquilizers)
Psychotherapy
Supervision/precautions/restraints/seclusion
Electroconvulsive therapy

**The assessor must explain or describe any indication of suicidal thoughts or behavior, whether or not it can be scored (i.e., outside of the 90 days [history of] or vague plan for future if condition worsens).**

**Scoring**

0) No suicidal behavior. May have a history of suicidal behavior that is not a current problem.
1) Requires occasional supervision and/or intervention.
2) Requires frequent supervision and/or intervention.
3) Requires constant supervision and/or intervention.

\+ **Disruptive Behavior**

Defined as: **inappropriate behavior that interferes with the normal activities of self or others and** requires intervention to stop or interrupt the behavior. Disruptive behavior may include but is not limited to: removing clothes inappropriately; stubbornness; sexual behavior inappropriate to time, place or person; excessive whining, crying or screaming; persistent pestering or teasing; constantly demanding attention; and urinating or defecating in inappropriate places.

**NOTE:**

▲ Keep in mind, that some disruptive behavior may be appropriate, such as: crying from pain, or repeatedly asking for toileting assistance during presence of urinary tract infection. (These would not be scored as disruptive).

▲ **THE TYPE OF BEHAVIOR AND INTERVENTION MUST BE SPECIFIED IN THE COMMENTS.**

**Scoring**

0) Does not occur or occurs at a low level not requiring intervention. May have a history of disruptive behavior that is not a current problem.
1) Occurs occasionally and requires intervention.
2) Occurs frequently and requires intervention.
3) Occurs constantly and requires intervention.

# IV. MEDICAL ASSESSMENT

## A. MEDICAL CONDITIONS

The assessor reviews the medical status by evaluating the medical condition and the need for medical services. If the customer is hospitalized or resides in a NF, much of this data may be obtained directly from medical records. If a home interview is conducted, accept statements by the customer or caregiver that seem to have clinical validity but verify pertinent facts by consulting with the physician, major health care provider or others who are well-informed regarding the medical condition of the applicant. While historic or chronic medical conditions are reflected, this section should give a thorough picture of the customer's **current** medical condition and immediate medical nursing needs.

This section is used to record the customer's diagnoses and specific medical conditions. The assessor should review all the conditions listed to ensure that no significant diagnoses are omitted.

If a specific stated diagnosis is not listed, but the diagnosis or condition is the same or essentially the same as one of the listed conditions, **select the existing condition and use the comment section to elaborate**. For example, if the stated diagnosis is Lou Gehrig's disease, select amyotrophic lateral sclerosis (ALS); if quadriplegia is the stated diagnosis, select paralysis. It is very important to carefully evaluate any condition that may relate to the diagnoses in bold print since these conditions determine the scoring group to which the customer is assigned.

**ICD-9 (International Classification of Diseases – 9th Revision)**

The assessor should identify any other significant diagnoses in the ICD-9 section. If you have an ICD-9 code that is not listed, select a misc – ICD – 9 code and enter the specific name and code in the comments section. **DO NOT list surgical procedures as diagnoses but they may be recorded in the summary section**.

***Acute (A), Chronic (C), History (H)**

The assessor should further describe the medical conditions indicated by selecting Acute, Chronic or History.

- "Acute" means an active condition having a sudden onset, lasting a short time and requiring intervention. (May still be considered acute if in the convalescent stage.)
- "Chronic" means a condition which is always present or occurs periodically or is marked by a long duration.
- "History" means a condition which occurred in the past and may or may not have required treatment and is not now active. **Include date or approximately when the condition occurred**.

*__Impacts ADLs__

Indicate for each applicable diagnosis whether it has detrimentally influenced the customer's ability to **independently perform** any of the ADLs in the past 30 days by selecting Yes or No. In order to select Yes, the impact or affect must be significant enough to result in a **current score** over 0 (zero) on the applicable ADL. In case of multiple, interrelated diagnoses, evaluate and indicate the impact of the medical condition that **most directly** affects the ADL, (e.g. hypertension ⇨ stroke ⇨ paralyzed leg = impairment in transfer ADL; in this case the paralysis most directly causes the impairment in ADL ability).

Select a Yes, if significant impact is current or is intermittent but ongoing.

Select No, if the diagnosis has had no significant impact or if the diagnosis did impact earlier, but is now resolved.

*__Medical or Nursing Treatment Required__ (for Medical Condition)

Medical/Nursing treatment is defined as: specific, ongoing medical, psychiatric, or nursing intervention used to actively resolve or prevent deterioration of a medical condition/diagnosis. Exclude treatment not currently in use **unless** those interventions are planned to be used intermittently on an ongoing basis (e.g., chemotherapy, dialysis). Treatment may include any services listed on the PAS Services and Treatments list or medical services identified in the PAS that fits the definition of treatment.

For each applicable diagnosis, indicate whether or not current, ongoing nursing or medical treatment/intervention is required (needed or received) by selecting either Yes or No. If treatment is not being received but is clearly needed to alleviate a medical problem caused by the diagnosis, circle Yes and record a comment to support your decision (e.g., customer has a decubitus and is not being turned and repositioned, but needs this nursing intervention to improve circulation to the decubitus). Rehabilitation potential must be taken into consideration when deciding whether or not an customter needs certain services (e.g., if an customer has already received speech therapy and reached the maximum potential benefit, speech therapy may no longer be feasible or needed. Also, the incontinent customer with Alzheimer's may have little or no ability to profit from bowel or bladder training). When indicating a need for treatment, it is necessary to provide comments to justify your decision, and that the service is reasonable and necessary.

Durable medical equipment (DME) and ADL assistive devices (hearing aids, glasses, wheelchair, canes) are not considered to be treatment **unless** the equipment is used specifically and actively to resolve the existing **medical** condition (e.g., clinitron bed is a treatment if it is used to prevent further breakdown of a wound or decubitus; a splint used to correct or prevent decline of contracture may be a treatment). If treatment received is inadequate, circle a Yes, but elaborate in comments.

Indicate if the diagnosis is considered most significant.

***Major Diagnosis**

The assessor should select up to three (3) major diagnoses. The major diagnoses may be obtained from medical records or if not specified, the assessor may determine which diagnoses are most significant based on which ones are most resource intensive (e.g., using the most medical/nursing services) or causing significant medical problems for the customer. For example, if an customer with a diagnosis of anemia and dementia is only receiving medication or restraints for dementia, then the major diagnosis would be considered dementia.

By Arizona Resivsed Statute an eligible person must have a non-psychiatric medical condition or developmental disability, that by itself or in combination with other medical conditions, places the person at risk of institutionalization in a nursing facility or intermediate care facility for the mentally retarded. Therefore an eligible person must have a non-psychiatric major diagnosis. See page 44 for more information on physician review on cases eligible by score with SMI diagnoses.

***Categories and Related Medical Conditions**

The PAS assessor must verify pertinent diagnoses and medical conditions per medical documentation or verbally from provider (by phone or in person) and should secure copies of documentation when necessary such as in the event of an eligibility review or hearing.

**Since some conditions determine the scoring group to which an customer is assigned, they are listed here along with other conditions that are either essentially the same or similar enough they should be marked under that section for scoring purposes**. These conditions are bolded below. See page 49 for more information on scoring.

For more examples of grouping diagnosis, see EPD PAS Manual Supplement "Medical Conditions and Associated Related Conditions".

1. Hematologic/Oncologic - disorders of the blood and conditions relating to tumors, malignant or benign.
2. Cardiovascular - conditions of the heart and blood vessels.
3. Musculoskeletal - conditions related to muscles, bones and connective tissue.

**Paralysis - (Includes but is not limited to the conditions listed below).**
Hemiplegia
Paraplegia
Quadriplegia
Paresis
Hemiparesis
Bells palsy
Guillain - Barré syndrome

4. Respiratory - conditions related to the act of breathing; involves the nose, trachea, lungs and all air passages.
5. Skin Conditions - diseases/disorders related to the skin on any/all parts of the body.
6. Neurological - conditions related to nerves, nervous tissue or nervous system.

- **Alzheimer's Disease, OBS, Dementia - (Includes but is not limited to the conditions listed below).**

  Alper's disease (grey matter degeneration)
  Pre-senile dementia (Pick's disease)
  Progressive dementia
  Multi-infarct dementia
  Arteriosclerotic dementia
  Degenerative dementia
  Jakob-Creutzfeldt disease (progressive viral disease of CNS)
  Cerebral Atrophy

- **Parkinson's disease - (Includes but is not limited to the condition listed below).**

  Paralysis agitans

- **Head trauma - (Includes but is not limited to the conditions listed below).**

  Concussion
  Closed head injury
  Skull fracture

- **Multiple sclerosis - (Includes but is not limited to the condition listed below).**

  Demyelinating disease of central nervous system

- **Amyotrophic lateral sclerosis - (Includes but is not limited to the conditions listed below).**

  Lou Gehrig's disease

7. Genitourinary - conditions related to the genitals and urinary system and also includes kidneys.
8. Gastrointestinal - conditions related to the stomach, intestines and related structure such as esophagus, liver, gall bladder and pancreas.
9. Ophthalmologic/EENT - conditions related to the eyes, ears, nose and throat.
10. Psychiatric - conditions related to the mind and mind processes.
11. Metabolic - conditions that relate to physical and chemical changes in the body, including endocrine disorders and electrolyte imbalances (e.g., hypokalemia, hypernatremia, malnutrition).
12. ICD-9s - disorders that are not covered in the above categories. The assessor should use this section only when the customer's condition is not covered in categories 1-11.

## B. MEDICATIONS/TREATMENTS/ALLERGIES

This section identifies the medications and treatments currently received by the customer. **If in a facility,medications may be obtained from the physician orders list.** . If the interview is in-home, request prescription containers and copy label information. If there is a discrepancy between the verbal report, prescription bottles and/or the medical records, note it as a comment. Also ask if the customer is taking any type of non-prescription medication. The assessor should include dosage, frequency, duration, route and form of each medication. Indicate whether the medication is prescription (Rx) or over the counter (OTC). If the applicant receives a PRN medication, note the prescribed frequency as well as the actual frequency taken. Include comments related to blood sugar levels, discontinued mediations (taken in last 30 days).

1. Total prescription (Rx) medications: ACE totals the number.
2. Total Over the counter (OTC) medications: ACE totals the number. Over-the-counter is defined as any medication that can be purchased without a doctor's order.
3. Needs assistance with medications? - Indicate if the customer needs or receives assistance taking medication or if the process is completed independently. Setting up of a medi-set or similar process would be considered assistance.
4. Therapeutic diet? A therapeutic diet is physician prescribed and based on an customer's medical condition. If yes, describe it. A regular diet or the need to cut up food would not be considered a therapeutic diet. A therapeutic diet is one that is adjusted to meet special nutritional needs and can be adjusted in consistency, level of nutrients, amount of fluids, number of meals or by the elimination of certain foods.
5. Medication Allergies: Note all medication allergies the customer may have.

## C. SERVICES AND TREATMENTS

### *Receives/Needs

The Medical Specialist should identify and services/treatments the customer received by selecting from the listed conditions. With information obtained from PAS sections on Medical Conditions, Medications and Treatments, from medical records and contact with health providers, select for any of the listed services/treatments. Do not consider recent but discontinued services. You may select as "receives", services that are intermittent but ongoing (such as chemotherapy). Services and treatments may be provided by professionals, non-professional caregivers, by customer, or others as appropriate.

In evaluating whether or not a service is **"needed"**, the assessor must make a professional judgment based on education/experience. He/she will identify the problem and render an opinion as to whether or not it is feasible that the service can resolve or alleviate the medical problem. For example, if the assessor identifies a problem such as incontinence in a severely demented customer, the assessor may decide that bowel/bladder training is not a realistic possibility. In that case **"needs"** would not be marked. Again, when indicating a **"need"** for treatment, it is necessary to provide comments to justify your decision, and that the service is reasonable and necessary.

### *Frequency of Service

Indicate the frequency of services by selecting continuous, daily, weekly or monthly. An ongoing service or treatment which lasts several hours or more may be considered continuous (e.g., continuous drip tube feeding or oxygen). It may be necessary to include comments to clarify the frequency of some treatments in order to help identify the severity of the condition (e.g., dialysis treatment three times weekly for 4 hours).

If the individual is receiving a service which is not adequate, select receives and use the comments section for clarification. If you select needs, you do not need to circle a frequency. If the individual is receiving no services or treatments and doesn't need any, make a note in the comments section.

1. Injections/IV

    a. Intravenous Infusion therapy - Fluid substance introduced into the body via a vein. This includes blood transfusions.

    b. Intramuscular/subcutaneous injections - Fluid substance injected into the muscle or beneath the skin via a hypodermic syringe.

2. Medications/Monitoring

   a. Drug Regulation - refers to the necessity for close evaluation/monitoring/ adjustment of medications to assure effective therapeutic value.

      Examples of drug regulation might include:

      - Periodic Lab test: blood sugar levels for antidiabetic agents, anticonvulsant blood levels (e.g., Tegretol), clotting time (e.g., Coumadin), cardiac drug levels (e.g., Digoxin).

      - Adjustment of medication dosage/schedule in direct relation to diagnostic testing or symptoms: (e.g., Hold Lanoxin if pulse below 60, hold Procardia if systolic blood pressure below 150, sliding scale for insulin dosage).

      - Intense supervision or observation that is needed to evaluate: adverse reactions, interactions, or immediate response to a drug such as response to a pain relieving narcotic such as Demerol, response to chemical restraints or drugs given for behavior control such as Haldol or Mellaril; or

      - Schedule II Narcotics.

   b. Drug regulation is not meant to refer to routine monitoring/evaluation/adjustment that is appropriately and readily accomplished by non-professionals, (e.g., "Aspirin upsets my stomach so I'll take Tylenol instead").

   c. Drug Administration - The act of giving or applying medication to remedy an illness or condition. Includes self-administration.

3. Skin Care

   a. Decubitus Care - Application of various materials or treatments such as Duoderm, Santyl, Collagenase, Betadine, ointments, bandages, heat application, whirlpool and debridement for therapeutic reasons to protect or assist in healing a pressure sore or stasis ulcer. Include preventive measures ordered by the physician for customers with histories of chronic difficulties which are likely to recur. **Use the comments section to describe the ulcer, stage, size, etc.**

   b. Wound Care - Application of various materials such as medicated solutions, ointments, gauze and bandages to assist in the healing or protection of a wound (incision, skin tears, burns, IV sites, dialysis sites) for therapeutic reasons. Does not include simple first aid measures or medication applied to skin conditions such as ACNE or DRY SKIN. **Use the comments section to describe the wound.**

c. Other ostomy care - Specific care needs, such as irrigation, cleaning or bandaging to maintain an artificial opening or a stoma. This excludes ostomy care for bowel or bladder ostomies, (covered in 5b.) or tracheostomies (covered in 6e.). Examples of other ostomies are gastrostomy and jejunostomy.

4. Feedings

   a. Parenteral Feeding/TPN - Nutrition administered through a route other than the alimentary canal, and usually intravenously.

   b. Tube Feeding - Nutrition administered through a tube (such as nasogastric, gastrostomy or jejunostomy tubes) to the alimentary tract.

5. Bladder/Bowel

   a. Catheter Care - Maintenance of urinary catheter patency and hygiene. Includes condom, indwelling and intermittent straight catheterization.

   b. Ostomy Care - Specific care (i.e., changing stoma ring, changing bag) necessary to maintain an artificial opening or stoma for bowel or bladder.
   c. Bowel Dilatation - Expansion of the anal orifice to promote evacuation.

6. Respiratory

   a. Suctioning - The process of removing or withdrawing secretions and waste material.

   b. Oxygen - Receiving $0_2$ per nasal prongs, face mask or $0_2$ tent (for example).

   c. SVN (small volume nebulizer) - Treatment using a machine that produces a fine spray or mist of a specific prescription for inhalation (**exclude** hand held atomizers/inhalers).

   d. Ventilator - A mechanical device for artificial ventilation of the lungs usually administered per tracheostomy (excludes C-PAP and Bi-PAP without a rate setting)).

   e. Trach Care - The process of suctioning and cleaning the stoma and apparatus that provides an artificial airway to the lungs through the trachea.

   f. Postural Drainage - The process of positioning so that gravity will allow drainage from nasal passages, airways and sinuses. Drainage is usually stimulated by percussion to lung areas.

7. Therapies

   a. Physical - Treatment provided for specific physical problems by or under the direction of a registered physical therapist. Therapies may involve use of physical agents such as hydrotherapy, exercises, electricity, radiation, and training in use of assistive devices.

   b. Occupational - Treatment provided by or under the direction of a registered occupational therapist that will assist the customer in the management of personal care. This therapy helps to improve the customer's functional abilities, teaches adaptive techniques for ADLs and works with upper extremity mobility.

   c. Speech - Treatment provided by or under the direction of a registered speech therapist for various speech and swallowing difficulties. Therapy helps the customer with comprehension and speech difficulties, provides restorative therapy and diagnostic/evaluation services.

   d. Respiratory - Treatment provided by or under the direction of a registered respiratory therapist to restore, maintain and improve respiratory function; (includes the use of C-PAP which may or may not be under the direction or provided by a registered respiratory therapist and Bi-PAP which always will be under the direction of a respiratory therapist).

   e. Alcohol/Drug Treatment - Medical or psychological counseling aimed at customers who abuse alcohol and/or mood altering drugs. May include self-help groups.

   f. Vocational Rehabilitation - Therapy directed at developing or redeveloping job-related skills.

   g. Individual/Group Therapy - Psychotherapy or counseling provided by a professional for treatment of mental or emotional disorders or maladjustment.

8. Rehabilitative- a professional nursing service that establishes a therapeutic plan of care that is problem oriented, individualized, and has measurable goals. This care plan's objective is to enable the ill or disabled person with rehabilitation potential to achieve optimum, practicable **functional efficiency**.

   - It provides for **direct** or **indirect** nursing care to restore functional ability or prevent further deterioration in ability.
   - Rehabilitative nursing is **not** monitoring although monitoring may be a component of the teaching/training process.
   - Rehabilitation nursing is **not** activity or exercise carried out for recreation/general health purposes.

a. Teaching/Training Program - To teach an customer or family caregiver routine tasks in relation to customer's medical need (e.g. diabetic testing, ostomy care, catheter care, diet planning, use of prosthesis, self administration of medication).

b. Bowel/Bladder Training - A formal method of establishing regular evacuation/urination by reflex conditioning.

c. Turning and Positioning - Moving, turning or repositioning an customer who is not able to move independently. This is done to improve circulation and to avoid decubiti or contractures.

d. Range of Motion - Active or passive exercise related to the restoration of a specific function or to maintain function. Excludes general exercises to promote overall fitness.

e. Other Rehab Nursing - Other rehab nursing services deemed appropriate to regain health or strength, under the direction of nursing or therapists, that is reasonable and justified (e.g., restorative ambulation, restorative feeding, deep breathing exercises, therapeutic splinting, or physical, occupational or speech therapy tasks performed by **nursing staff/caregiver** at the direction of the therapist).

9. Other Services And Treatments

a. Peritoneal Dialysis - Removal of waste products from the body by perfusing prescription solutions through the peritoneal cavity.

b. Hemodialysis - Removal of waste products by circulating the body's blood supply through special dialyzing tubes.

c. Chemotherapy/Radiation - The application of chemical or x-ray agents that have a specific and toxic effect on cancerous cells.

d. Restraints - Devices that hinder or restrict movement to protect an customer from injury.

**Mechanical:** Physical devices or barriers that restrict normal access to one's body or immediate environment and to protect from injury. May include devices (attached or adjacent to the body) that cannot be easily removed such as vest, wanderguard, seat belts, gerichair with laptray or barriers to normal, standard movement (e.g., locked rooms or areas). Usually, devices such as side rails or self-removable seat belts will **not** be considered restraints.

**Chemical:** Prescribed medication used for elimination or modification of **overt physical behaviors** likely to cause physical harm to self or others (e.g., combativeness, constant pacing, or self mutilation).

- A specific drug must be linked with a particular behavior and used to eliminate or control the specific behavior.

- Verbal reminders/redirection by others, shielding, deflecting, guiding or bracing a body part for completion of a procedure is **not** a restraint.

e. Fluid Intake/Output - Measuring and monitoring the oral and parenteral intake of fluids and/or the fluid output (e.g., IV fluids, tube feedings, parenteral feedings, specific fluid intake or urine output, catheter output, vomitus and other fluid loss). Routine recording of dietary intake or supplements (e.g., percentages) is not I & O.

f. Other - Includes other therapies prescribed for a specific problem (e.g., sitz bath, TED hose, TENS unit for pain, special mattress, whirlpool (if used for reasons other than physical therapy or decubiti care, it should be noted here). Any service or treatment received or needed **but not documented elsewhere** should be indicated here. This is essential if a diagnosis is marked as requiring services or treatment. For example, if peripheral vascular disease is marked as receiving treatments because the A/R requires TED hose; then the TED hose should be indicated here if not documented elsewhere.

## D. SUMMARY

The personal contact information will be date entered here. See page 12.

In this section the assessor will summarize the overall medical conditions, functional status and needs of the customer. The assessor should avoid making statements regarding eligibility, the advisability of any particular placement or need for institutionalization. The following factors **must** be included when completing the summary, if applicable:

1. A brief description of the customer's current major medical condition and related problems; any conditions which are unstable or requiring significant treatment should be described. Any vital signs, pertinent lab data, and other diagnostic information should be noted (i.e., blood sugars, blood pressures, MRI, CT scan).

2. Descriptive information regarding ADL performance, functional limitations and capabilities;

3. Formal and informal support system (e.g., describe formal services received such as meals on wheels, or any informal services or support provided by relatives, neighbors, and friends);

4. Environmental conditions and living situation/arrangement;

5. Psychosocial factors, behaviors, cognitive abilities (describe the impact upon health status and caregiving);

6. Nutritional status (e.g., chewing or swallowing problems, unusual eating patterns, major fluctuations in weight);

7. Sensory status (describe any significant impairment in sense of touch or any other sensory impairments);

8. Any other information the assessor feels is necessary to document including statements made by the customer or caregiver such as what services are desired, any unmet needs observed or described. The assessor should avoid statements which reflect any personal value judgments or biases.

## E. PHYSICIAN REVIEW?

The assessor should indicate the reason a review is requested. Eligibility review is an integral part of the PAS assessment process. It is designed to address those customers whose score outcome is not thought by the assessor to be a complete reflection of the customer's **need for nursing facility level of care**.

It is important to remember that there is no singular criterion for the entry level of care for ALTCS medical eligibility. An eligible individual might have a combination of factors that impact their functional ability and medical need for services. An customer who needs the entry level of care will require care greater than what is considered supervisory care (ARS-36-401 [unskilled nursing care]) and may present a combination of the following needs or impairments:

1) requires nursing care by or under the supervision of a nurse on a daily basis;
2) requires regular medical monitoring;
3) impaired cognitive functioning and psychosocial deficits;
4) impairments in ADLs and incontinence.

Eligibility reviews may occur for customers who score either below or above the entry level scoring threshold or have impairments in some aspects (as described above) that "overshadow" their strengths in other areas. These reviews will usually be performed by a physician consultant or an administrative process. An customer cannot be determined ineligible by an administrative process.

Reviews **must** be requested for:

- Ineligible cases scoring 56 or more on an initial PAS.

- All ALTCS customers who do not meet threshold score for ALTCS or Transitional reassessment.

- All transitional cases residing in a Nursing Facility.

Reviews **may** be requested for but are not limited to these cases:

- Customer does not meet threshold score but the assessor thinks the customer may be at risk of institutionalization;
- Customer meets threshold score but has a psychiatric condition (includes chemical dependence) and does not have a non-psychiatric condition or developmental disability that by itself or in combination with the psychiatric condition places the customer at risk of institutionalization;
- Customer requests a hearing;
- Customer meets threshold score on an initial ALTCS application who is already a member of an AHCCCS health plan and appears to need less than 90 days of convalescent care;
- Atypical cases: traumatic brain injuries, HIV/AIDS, specialized treatments, e.g., halo brace, body cast, any cases requiring extensive and complex medical care.

**PAS Override**

A PAS decision can be overridden based on the following reasons:

- Physician Review;
- Administrative Review;
- Hearing Review;
- Hearing Decision.

**Level of Care**

After the PAS has been entered into ACE, the computer calculated level of care for eligible customer's should be entered here. The ACE scoring tab shows the level of care (LOC) code:

I = Intermediate (ICF) Class I
P = Skilled (SNF1) Class II
S = Skilled (SNF2) Class III
V = Skilled (SNF3) Class IV (Ventilator Dependent)
M = Intermediate Care Facility/Mentally Retarded (ICF-MR) (DD Only)
T = ALTCS Transitional

For more information on LOC see ALTCS Eligibility Policy and Procedure Manual, Chapter 1000.

One section of the Physician's Review document is used by the PAS assessor/s to document reasons for requesting an eligibility review.

**Requested Date**

Date the case is actually sent to review.

**Requested Comments**

When requesting an eligibility review, the assessor should provide a specific reason based on the customer's functional and medical conditions. Any information recorded must be factual and objective. Do not suggest an eligibility decision. Upon requesting an eligibility review, the assessor should provide the reviewer with current documentation if available and pertinent to the A/R's condition. Documentation should be selected for its ability to **CLARIFY** the current medical condition. **If this documentation is NOT available note that in this section.**

This documentation may include:

- History and Physical;
- Discharge summary if the customer was hospitalized;
- Consultations by specialists (e.g., psychological, neurological or cardiological);
- Therapy notes;
- Nursing notes only if addressing a specific incident or condition;
- Test results such as x-ray, laboratory, EEG, EKG or MRI results;
- Progress notes;
- MDS (Minimum Data Set), if A/R in NF;
- Prior PAS.

## Referral

This is the method of obtaining the Physician Review docuemtn to be sent to the physician reviewer.

## ■ Eligibility Reviewer's Summary

In this section the reviewer determines, independent of score, if the customeris at immediate risk of institutionalization in a NF. The summary will describe significant factors that determined eligibility and may include:

- A brief summary of the significant medical conditions;
- Discussion of the extent of the impact the current medical condition has upon physical/mental functioning;
- A prognosis with an estimate of chances for recovery or satisfactory maintenance of health without ALTCS intervention. For example, the customer may be served adequately through supervisory care facilities, periodic outpatient care, or intermittent hospital stay;
- An opinion about the stability of the medical condition; how likely is it that symptoms will recur or the severity of the condition will become worse or cause significant impairment in mental or physical function, over the course of the next few months.

In conducting the review, the reviewer/s may consider all available information from the PAS as well as any additional documentation provided by the assessor. The reviewer may call and discuss the case with the assessor or the customer's primary care physician for further information. In making the determination, the reviewer may consider several areas such as functional limitations; cognitive deficits; stability of medical conditions; number, frequency and complexity of treatments, to list a few. The reviewer may place a different degree of significance on factors within each individual case. The reviewer must look at the case from the overall perspective of risk of institutionalization, in conjunction with the combination of conditions, impairments and other limitations which may be the deciding factors.

### Review Results/Physician's decision

After the review is completed, the reviewer indicates the appropriate decision, eligible or ineligible.

### LOC (level of care)

The reviewer will indicate the recommended LOC for all customers considered eligible.

**Reviewer's Signature and Title/Name of Doctor**

The reviewer's name and title should be indicated.

**Review Date**

Date reviewer completed the review.

# V. POSTHUMOUS PAS AND REASSESSMENTS

## A. POSTHUMOUS PAS

In some instances an initial PAS may need to be completed after the customer has expired. The customer may have died after the application has been made, or in some cases a representative may have applied for the deceased customer.

If the eligibility interviewer is aware that the customer is deceased, an alert is automatically sent to medical eligibility and the date of death will appear on the PAS Intake Notice. In some cases, the customer may die after the PAS referral has been made, and Financial Eligibility may be unaware of the death. In that case, **the PAS assessor will be responsible for notifying Financial Eligibility** of the date and place of death and source of this information.

Although the posthumous PAS may be an initial PAS, there are limitations on information availability and applicability.

- Change in ADL function;
- Change in bladder continence;
- Medications – totals for OTC and Rx as well as whether or not assistance is required in administration;
- Therapeutic diet;
- Number of hospitalizations, ER visits, falls'
- Whether the client is hospitalized or has plans for discharge; and
- PASRR tracking questions.

**A deceased customer must have been placed in a nursing facility during the application period in order to be considered PAS eligible.**

## B. REASSESSMENTS

PAS reassessments are required on certain cases to determine continued eligibility for ALTCS. The same basic PAS criteria must be met in order for eligibility to continue. Any changes in score or condition **must** be explained in comments or in the summary. Each reassessment should give a complete description of the customer's current functional and medical status. To insure consistency and to prepare for the interview it is necessary to review the PAS file or PAS screens prior to conducting a reassessment. If at all possible, a reassessment should not be completed on a hospitalized client.

Prior to completing an ineligible reassessment the assessor must have contacted the case manager to obtain collateral information and to discuss the potential ineligibility. Prior to completing a reassessment on a customer that scores into the Transitional Program and resides in a nursing facility, the case manager should be consulted regarding discharge planning.

There are a few differences in requirements between the initial PAS and a reassessment that should be noted. The following non-scored items are not to be completed on PAS reassessments:

- Whether or not the customer is hospitalized, and the plan for discharge.

  ACE will not allow entry of these fields on a reassessment.

  For more information on Reassessments, see ALTCS Eligibility Policy and Procedures manual, chapter 1000.

## VI. SCORING

Three (3) scores are given under the PAS screening tool:

- a functional score;
- a medical score; and
- a resulting grand total score.

The medical score is dependent upon which Group (1 or 2) a customer is assigned. This assignment is based on the customer's diagnoses and is designated as follows:

**IF APPLICANT**

| | |
|---|---|
| Has a diagnosis of paralysis, head trauma, multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS) or Parkinson's disease which impacts either the A/R's ADLs or requires treatment.<br><br>SCORE AS GROUP 1 | Has a diagnosis of organic brain syndrome, Alzheimer's disease or dementia which impacts either customer's ADLs or requires treatment and does not meet Group 1 criteria.<br><br>SCORE AS GROUP 2 |

ALL OTHERS ARE SCORED AS: GROUP 1

ALTCS eligibility for the elderly and physically disabled generally requires a minimum grand total score of 60. A customer generally will be ALTCS eligible when the following minimum score is achieved:

GROUP 1
- Functional score of 30
- Medical score of 13

GROUP 2
- Functional score of 30
- Total score of 5 in the orientation section or
- Raw (unscaled) score of 2 for any single behavior in the emotional/cognitive behavior section.

A computer-generated score sheet should be printed after each PAS is completed in ACE.

For more details see the flow chart for EPD scoring, Appendix A-3.

## PAS Completion

Before completing a case the assessor **must** review the system to ensure accuracy of data entry on all screens. All scores must be reviewed for accuracy and the content of comments and summaries must also be reviewed. **If the assessor assigned the PAS is not available to complete the PAS, whoever completes the PAS is responsible for reviewing and ensuring the accuracy of the information as defined above.**

If the assessor feels the customer's condition may improve (e.g., recent fracture or other acute episode) the case should be referred to his/her supervisor prior to completing as a reassessment in 6 months may be indicated. (CA070)

Before completing a case that has had a Physician Review completed, the assessor must review the Physicians comments and recommended Level of Care.

If the assessor questions the physician review or the level of care, the case should be discussed with the supervisor, regional or branch manager, or ALTCS medical eligibility manager **prior to completing**. It is important to note that the final completing of the case and eligibility determination is done by Financial Eligibility.

For Information on Eligibility Review Types, see page 45.